FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**

- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**

- Build on data ***already collected*** by HCFA quarterly enrollment and expenditure reports, **AND**

- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FINAL 1/25/01

FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **Nebraska**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name (s) **Kids Connection**

SCHIP Program Type **XX** Medicaid SCHIP Expansion Only
____ Separate SCHIP Program Only
____ Combination of the above

Reporting Period **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

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Submission Date **January 25, 2001**

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program's changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

1. Program eligibility
   Additional disregards of types of income. e.g. Americorps volunteers and Reparations to victims of Nazi persecution.
2. Enrollment process
   Implemented a shortened redetermination form that requires less verification.
3. Presumptive eligibility
   More qualified providers have been trained and approved to determine presumptive eligibility for children. There are over 70 trained and participating entities statewide.
4. Continuous eligibility
   NC
5. Outreach/marketing campaigns
   Nebraska has a statewide community-based network to outreach to potentially eligible families. The network consists of public health nurses (commonly referred to as PHONE – Public Health Outreach and Nursing Education), Voices for Children (Nebraska's Robert Wood Johnson Covering Kids grantee with 3 pilot project sites), and Access Medicaid (Nebraska's enrollment broker for Medicaid managed care). In the 3rd year of operation, the networks are now fully staffed.
6. Eligibility determination process
   NC
7. Eligibility redetermination process
   NC
8. Benefit structure
   NC
9. Cost-sharing policies
   NC
10. Crowd-out policies
    NC
11. Delivery system

NC

12. Coordination with other programs (especially private insurance and Medicaid)
    NC
13. Screen and enroll process
    NC
14. Application
    Revisions to the current application include: 1.) Clarifying that the application can be used for processing CHIP (Title XXI) and Children's Medical Assistance (Medicaid/Title XIX Poverty Level programs) eligibility; 2.) An explanation of eligibility related to private health insurance; and 3.) Revising the calculation instructions families use to determine if they may be eligible to more accurately reflect how the Health and Human Services (HHS) local office will calculate countable income. The revised application will be printed with the release of the 2001 federal poverty guidelines.
15. Other

1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.

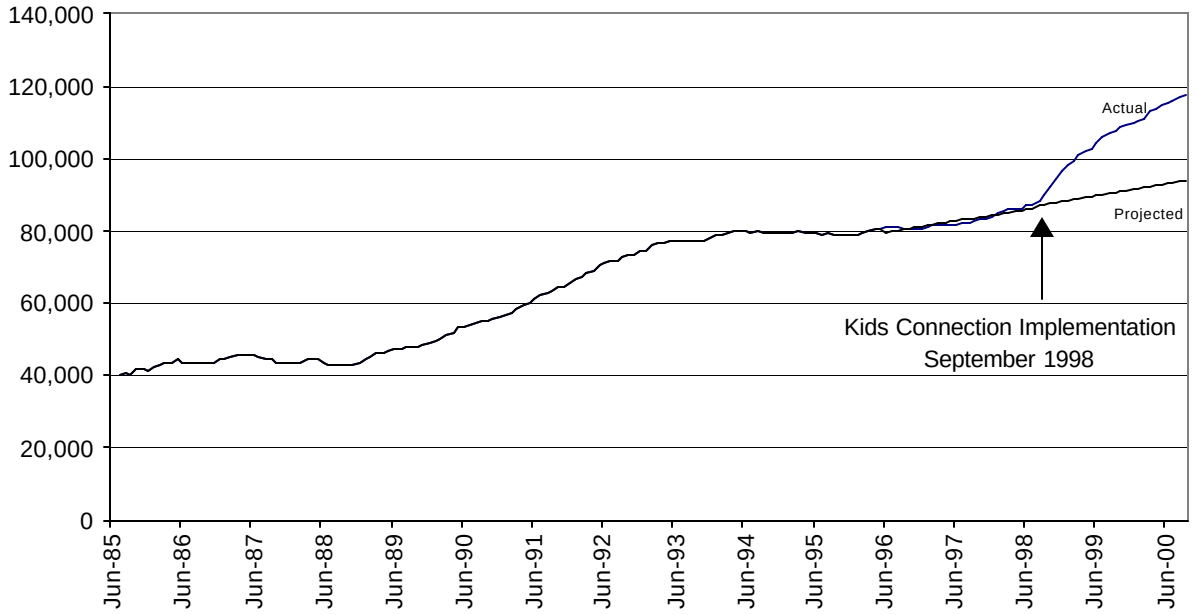
1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.
   Through the expansion of Nebraska's Kids Connection program, it is clear that more children are covered who were previously uninsured.

   The base information for uninsured children comes from Current Population Surveys conducted by the U.S. Bureau of the Census. Using the initial Census estimate averaged from 1993, 1994 and 1995, Nebraska HHS estimated that 148,800 children were below 185% of poverty and 24,000 of these children were uninsured.

   For estimating the impact of Kids Connection since 1998 on uninsured children, Nebraska projected the 1997, 1998, 1999 Census data to March 2000, Nebraska estimates that there are 132,000 children living in families with incomes below 185% of poverty. Medicaid and the enhanced CHIP program covered 113,000 children in March 2000. Therefore, 19,000 children in families with income levels below 185% of poverty were without Medicaid or CHIP. Based on the most current estimates, that 45% of the non-Medicaid-covered children have no insurance, Nebraska estimates that 8,000 children remain uninsured in the state. The remaining 55 percent of the children living in families with incomes below 185% of poverty not covered by Medicaid or CHIP have other health insurance coverage.
2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

Following the implementation of the Kids Connection program in September 1998, many more children received medical coverage. Over the immediate preceding two years prior to Kids Connection, Nebraska was experiencing an increase in Medicaid children at a rate of about 3 percent per year. Assuming this rate of increase would continue, Nebraska would have had approximately 92,448 children eligible in an average month for FY 2000. In reality, Nebraska had 113,011 children eligible during the year. Using these assumptions, Nebraska estimates that an additional 20,563 children in an average month were made eligible because of Kids Connection outreach and enrollment activities. In other words, all other things held constant, these are the number of children added above the "natural" rate of increase. Of these additional children, 6,677 were CHIP (Title XXI) eligible and 13,886 were Medicaid (Title XIX) eligible.

Trend in Number of Children Eligible for Medicaid/Kids Connection
July 1985 to September 2000



3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

In sheer numbers, Nebraska's Medicaid and CHIP programs are covering many more of Nebraska's low-income children. In March 1998 (prior to Kids Connection), Nebraska's program covered approximately half of all estimated children below 200% of the federal poverty level (86,000 of 148,000 children). Currently, Nebraska covers over two-thirds (67 percent) of all children below 200% of poverty (118,000 of 175,000 children).

According to the Current Population Survey data for Nebraska, the number of children living in families with income below 200% of poverty was estimated to be 175,000 (average estimate for 1997, 1998, 1999). This number declined from the previous year's estimate by 10,000 children. As of March 1998, Nebraska covered 86,000 children under the Medicaid program. This equates to 49% of all children living in families below 200% of poverty. As of September 2000, Nebraska covered 118,000 children. This equated to 67% of all children below 200% of poverty. Therefore, Nebraska concludes that the program is reducing the number of low-income uninsured children.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

XX No, skip to 1.3

The estimate of the number of uninsured children in the state living at 185 percent of poverty has been updated based on 1997, 1998, 1999 Census Population Survey data.

____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2: List the performance goals for each strategic objective.
Column 3: For each performance goal, indicate how performance is being measured, and

progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter ANC@ (for no change) in column 3.*

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.
Measurement of the number of well-child visits has been impeded by the reliability of data provided to the state by the Medicaid managed care plans. With a 34 percent increase in the number of enrolled children, there is an additional burden placed on primary care health providers to meet the need for a medical home for all eligible children. Increased patient loads may result in providers focusing on ill-child visits to meet the increase demand with less emphasis on well-child visits. Another factor influencing the number of well-child visits per 1,000 enrolled children is the fact that while the total number of covered children increased 34 percent, a disproportionate share of the newly enrolled children are 15 to 18 years old. Enrollment for 15 to 18 year old children increased 45 percent while enrollment for children birth through age 14 increased 28 percent. Adolescents tend to have fewer well-child visits than younger children. Nebraska's plan to address the issue of increasing the number of well-child visits per 1,000 enrolled children through our contracts with school districts to perform EPSDT Administration and Outreach, increased support for EPSDT Administrative activities with the public health nurse network, and state participation in the Government Performance Review Act (GPRA) project to develop a baseline and evaluate immunization rates for children in Nebraska.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.
NA

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Nebraska Health & Human Services Finance & Support (Biennium starting FY2000)
Program 344 Children's Health Insurance Program (CHIP) Program Objectives:

- **Provide health care coverage to uninsured children in the state**
  Measured by # of children determined eligible for Title XXI compared with the # of uninsured children in the state in families below 185 percent poverty level (June 2001)
- **Create a simplified application process**
  Measured by # of Kids Connection applications processed (June 2001)
- **Enable access to timely and appropriate health care in order to prevent disease, treat problems, and maintain good health and development**
  Measured by # of EPSDT/HEALTHCHECK visits reimbursed through Title XXI (June 2001)

Nebraska has indicated our intent to participate in HCFA's Government Performance Review Act (GPRA) project to develop a baseline and evaluate immunization rates for children.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

ATTACHMENTS:

Kids Connection Study Committee Report to the Legislature (September 2000)

Kids Connection Monthly Eligibles Report

Composite of quarterly report outreach activities for Public Health Outreach & Nursing Education (PHONE/public health nurse network)

Quality Focus Studies and Reports performed by the State contracted EQRO:

Initial Prenatal Care
Management of Diabetes

FY2000 Client Satisfaction Survey Reports from the two HMO Managed Care Plans

Executive Summary

UnitedHealthcare of the Midlands, Ince. 2000 Customer Satisfaction Survey
Exclusive Healthcare, Inc. 2000 Member Satisfaction Survey

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.
NA

2. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

   Number of adults_____
   Number of children_____

3. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in:

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).
NA
2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

   Number of adults_____
   Number of children_____

2.3 Crowd-out:

1. How do you define crowd-out in your SCHIP program?
Crowd-out is defined as families dropping private health insurance coverage to qualify for eligibility for CHIP.
2. How do you monitor and measure whether crowd-out is occurring?
A one-time telephone survey was conducted in June 2000 to assess crowd-out.
3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.
Nebraska completed a survey this summer of families with children enrolled in Kids Connection to assess if families were purposely dropping other health coverage to become

eligible for CHIP. The phone survey included a total of 753 children ages birth through 18 years old living in 309 families.

The findings from the survey indicate that the Kids Connection program did not significantly pull children from recently dropped private health coverage. A concern about Kids Connection was that it would not only attract children who were continually uninsured for medical coverage, but it would also attract children of families who immediately dropped private insurance to gain access to new medical coverage. The survey showed that Kids Connection expansion worked as intended without drawing from the private insured population.

Based on survey data, 37 percent (279 out of 747) of the children enrolled in Kids Connection never had medical insurance coverage prior to Kids Connection. For those that did previously have insurance, the survey asked several more probing questions. Asking if children had coverage in the year before applying for Kids Connection, the survey data showed that another 26 percent of the total number of children (191 out of 747) had health insurance sometime in their lifetime but not in the year prior to enrolling in Kids Connection. The remaining children (37 percent) had health insurance in the year before applying for Kids Connection. For those children insured in the prior year, the survey then asked how long before being enrolled in Kids Connection did they have insurance. Out of the total children, only 6 percent (44 out of 747) stated that they had private medical insurance 6 months prior to enrolling in Kids Connection. Therefore, the survey data indicates that Kids Connection families rarely drop private health insurance to gain access to the public program.

For a summary of the survey findings and survey data, please refer to the attached Kids Connection Study Committee Report.

1. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.
   NA

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

- **Application**

  The Kids Connection application was distributed to all Nebraska public school districts for the 3rd year in August 2000. Distribution of the application through the public schools has proved to be the primary vehicle for contacting children of all income levels. School principals and superintendents are notified by letter 4-6 weeks in advance of the mailing and approximately 350,000 applications are shipped to school district offices. This massive effort provides the opportunity for parents from all background to enroll their children in Kids Connection using the single-page front/back

application form and provides a statewide toll-free telephone number for parents to call with questions or for more information.

In addition, the combined 6-page brochure/application is currently being displayed and distributed in pharmacies statewide, physician offices and clinics, at community action agencies, hospital emergency rooms and admission offices and local Health and Human Services offices. Printed at $.04 each, it serves as the main promotional/informational piece for Nebraska's program.

Effectiveness of distribution of the application has been measured by response of families in returning completed applications following the statewide school distribution. When polled through surveys, enrolled families and callers to the state's toll-free telephone line, overwhelmingly respond that they heard about the program through their school.

- **School Nurse Referral Card**
  Developed in cooperation with the Nebraska School Nurses Association and implemented in January 2000, the school nurse referral card provides a tool for school nurses to document their findings and receive recommendations for school accommodations when children are referred to a health care provider. The referral card provides parents with information about the availability of health care coverage for children at the time of a health care need. School nurses and health care providers utilizing the referral card have indicated that it is an effective tool for improving communication with families and health care providers and informing parents of the availability of Kids Connection.

- **News Releases**

Kids Connection Starts School Nurse Referral Card Program	**1/31/2000**
Kids Connection recognized by President Clinton	**7/18/2000**
Public Schools Receive Kids Connection Applications	**8/3/2000**
Governor Recognized Kids Connection Study Committee	**9/9/2000**
Number of Uninsured Children Cut in Half	**9/9/2000**
Governor Johanns Praises Kids Connection	**9/9/2000**
Nebraska's Kids Connection Targets Final 12,000 Kids	**11/15/2000**

- **HHSS Website**
  In November 2000 the Kids Connection Web Page averaged 383 hits per day

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?
   - **Application**
     Distribution of the Kids Connection application through the public schools proved to be the primary vehicle for reaching families with school age children of all income levels and ethnic backgrounds. Effectiveness has been measured by the increase in applications, increase in telephone calls to the toll-free hotline, and increase in

children enrolled in the program.

- **Partnerships**
  Collaborative partnerships with other entities such as the statewide public health nurse network and the Robert Wood Johnson Grantee, Voice for Children, have been effective in conducting outreach at the community level. This partnership helps to address the "stigma" issue many rural families have expressed by providing professional nurses that answer questions about the program, assist families through the application process and refer families to other services when necessary. Effectiveness is measured through evaluation activities reported to the Robert Wood Johnson Foundation as part of the Covering Kids grant and quarterly reports provided to HHSS by the public health nurse network.

- **Center for Rural Health Policy "Expanding Health Insurance Coverage to Children in Farm Families"**
  Through a $20,000 one-year grant from the Center for Rural Health Policy, additional partnerships have been fostered between the public health nurse network (PHONE) and the county Farm Service Agency offices to outreach to farm families. The public health nurse network, working with representatives from Nebraska's 80 Farm Service Agencies, will promote Kids Connection, assist families to complete an application, and provide referrals to other programs such as WIC, Commodities, Immunization Clinics, etc. Grant activities began October 1, 2000. Effectiveness will be measured by evaluating enrollment of children in rural Nebraska.

3. Which methods best reached which populations? How have you measured effectiveness?

- **Media**
  News releases target a broad range of the general population. While it is non-specific, the print media can be very effective in disseminating information about the program or enrollment opportunities. Seven print releases were distributed statewide during calendar year 2000.

  Television coverage and radio interviews have proven to be a very effective method of outreach to potentially eligible families. News releases are distributed to television stations and radio stations at the same time they are sent to print media. A request for a television or radio interview from the station often occurs following the receipt of a news release. These activities have proven to be very effective in increasing awareness of the program and motivating families to get additional information by evidence of tracking telephone calls to the statewide toll-free telephone help-line following each interview. Requests for applications and questions about the program increase substantially following television and radio interviews. Airing television and radio Public Service Announcements (PSAs) does not seem to have the same effective on telephone activity regardless of whether the PSAs are run during "purchased" time or as a true (free air time) PSA announcement.
- **Speeches & Presentations**

Presentations during the 3rd year of the program have included press conferences as well as talks and question and answer sessions with community groups. The press conferences, with high-level government officials and physicians addressing the media have proved effective in providing information to the media in a timely manner with the resultant story being positive for the program. News releases always accompany a press conference, providing direction for the story and key details and facts.

Community presentations provide an opportunity for families to obtain information about the program and ask questions relevant to their specific situation. The statewide network of public health nurses have played a key role in conducting community presentations with various audiences including families, health care providers, businesses and other community groups. Voices for Children, Nebraska's Robert Wood Johnson grantee, has developed a Speaker's Packet which is available to assist local staff in presenting an accurate consistent message about Kids Connection. The packet provides overheads, a power point presentation, handouts and speaker's notes. The speaker's packet contains customized information to address the audience's needs (e.g. business, families, and health care providers).

- **Community Focus Groups**
  During the period of July 10, 2000 to October 25, 2000 the Nebraska Children and Families Foundation, in collaboration with the Nebraska Health and Human Services Partnership Council, conducted 106 key informant interviews of providers and stakeholders, 12 community provider/stakeholder focus groups, 7 community consumer focus groups, and 11 community special population focus groups in communities all across Nebraska. 260 people participated in the community focus groups and HHSS policy cabinet members attended all of the community forums. While a variety of issues were covered, the initial focus of this input was "What is working well and why?"

  While specific HHSS programs or services were often mentioned, consensus about how these programs are doing was rare. For example, there were many respondents who felt that "Employment First" was working well but there were also a number of people who had complaints about the program. There were, however, a few HHSS programs, such as Kids Connection, the System Advocate, and Presumptive Eligibility for Medicaid, where there seemed to be almost universal agreement that they were "working well" and might be considered models to learn from.

2.5 Retention:

1. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?
   Simplified application and redetermination forms.
   No face-to-face interview required at initial application or redetermination.
   Less verification required.
   12-month continuous eligibility.

Monitor the reasons for closing children from medical coverage.

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

___ Follow-up by caseworkers/outreach workers

XX Renewal reminder notices to all families

___ Targeted mailing to selected populations, specify population _____

___ Information campaigns

XX Simplification of re-enrollment process, please describe _____

Simplified form; Redetermination by mail; verification required only if changes are reported.

___ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe_____

___ Other, please explain_____

3. Are the same measures being used in Medicaid as well? If not, please describe the differences.
   Yes for the Federal Poverty Level Children's Medical Programs.

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?
   12-month continuous eligibility.
5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.
   NA

2.6 Coordination between SCHIP and Medicaid:

1. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.
   Yes. Nebraska's CHIP program is a Medicaid expansion and uses the same forms and procedures.
2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.
   The same caseworker would handle the case and make the appropriate change from Medicaid to CHIP or vice versa.
3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.
   Yes. Children enrolled in CHIP and Medicaid in the designated Medicaid managed care geographic area would participate in Nebraska Health Connection, Nebraska Medicaid's managed care program. Children outside the managed care geographic area would receive medical services on a fee-for-service basis. Children statewide receive mental health services through a pre-paid health plan.

2.7 Cost Sharing:

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?
   NA
2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health service under SCHIP? If so, what have you found?
   NA

2.8 Assessment and Monitoring of Quality of Care:

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.
   For FY2000, the three primary care health care plans report quarterly to the State on outreach, case management, disease state management, prevention and education activities. Also included is information on complaints, grievances and appeals and denied claims. The State then performs an onsite review at the Health Plan site for further detail. The Health Plans began receiving specific health status information electronically, as reported by the enrollee during the enrollment process and through the annual Health Status update process. The enrollment broker relays immediate health needs to the Health Plan via FAX. The quarterly reporting process began with the Mental Health Substance Abuse System (MHSAS) contractor August 1, 2000.

   Analysis of the EQR client satisfaction survey indicates 77 percent of clients surveyed reported receiving well child visits and immunization reminders. 80 percent reported the child's personal doctor or nurse spoke to them about the child's feelings, growth or behavior. A high proportion of children had emotional or behavioral problems. Several unsolicited comments were received about the difficulty of getting dental care. (Dental services are covered by Nebraska Medicaid but are carved out of the managed care benefit package.) On a score of 1-10 with 0 as the worst and 10 as the best, 79 percent of the clients reported the child's personal provider as an 8 or higher. Between 19-26 percent of children needed to see a specialist in the last 6 months and 10-13 percent of those reported a "big problem" getting the needed referral. (Responsible adults are surveyed about the child's health care.)

   Combined client satisfaction data from the two HMOs indicated the key target areas for future improvement were: problems getting referrals to specialists, problems understanding written materials, problems with paperwork, low ratings of doctor or nurse, and low ratings of specialists. Areas where significant improvement or positive ratings were received were: getting a doctor or nurse, getting necessary care and delays in care waiting for approval, doctors and nurses listening carefully and providing understandable information and being treated with respect and courtesy.

As part of the State's onsite review of the Health Plans, the state reviews a physician corrective action plan. All corrective action plans were successful with improvement shown.

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?
   As part of the primary care Health Plan's physician credentialing process, the Health Plan reviews a sample of medical records to evaluate immunization and well child checks. Any physician falling below a threshold percentage receives a letter with his/her score and a comparison. The physician is then given an opportunity within a certain timeframe (90-120) days to improve his/her score.

   Also this year for the first time, the two HMOs reported Medicaid HEDIS data and provided a copy of the report to the State. The State is still in the process of reviewing this data.

3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?
   Plans include: reviewing and analyzing the HEDIS reports, reviewing and analyzing encounter data as it becomes more available and reliable and using the Quality Improvement Committee to review the data and make recommendations to the Medicaid Program.

   The initial Quality Improvement Committee meeting is scheduled for January 23, 2001. Eleven physicians were invited to participate for one year on this committee to review available data and reports and make recommendations for a permanent Quality Improvement Committee. The first meeting's agenda includes presentation of the EQR reports on Asthma and Prenatal Care. In addition to these reports the Governor's Blue Ribbon Task Force report on Infant Mortality and the State Asthma Team's data report will soon be available for inclusion.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

1. Eligibility
   NA
2. Outreach
   Nebraska has partnered with several organizations in the public and private sectors to promote Kids Connection and encourage enrollment. Examples of the organizations include: Voices for Children in Nebraska, Nebraska School Nurse's Association, Nebraska Grocer's Association, Nebraska Medical Association, Nebraska Pharmacist's Association, Nebraska Association of Health Care Systems, and Bosseleman's Gas Station and Convenience Stores in Nebraska.

   Distribution of applications through the public school districts in the student packets, direct mail and television interviews with local stations have been highly successful as measured by the increase in phone calls to the statewide toll-free telephone number and increase in number of applications received and processed following those activities. Outreach to children and families continues to be a focus for Nebraska's statewide public health nurse network which contracts with HHSS to provide EPSDT administrative activities. A new initiative to reach rural families began through a grant from the Center for Rural Health Policy to outreach to farm families through Farm Service Agency offices at the community level with the state's network of public health nurses.

   The Nebraska Health and Human Services System has won awards at the National Public Health Information Coalition (NPHIC) annual conference in October 2000 for Kids Connection materials. The awards included two Silver Awards for the Kids Connection Brochure/Application and the Media Kit for the Kids Connection First Year Anniversary Conference and a Bronze Award for the Kids Connection Poster. The Kids Connection Program was also rated 8th in the nation in reducing the number of uninsured children in the state by the Health Division Children's Defense Fund ("All Over the Map A Progress Report on the state Children's Health Insurance Program" July 2000)

   Based on anecdotal information, barriers to enrollment may include culture and language. Providing informational materials on a multilingual basis is essential, as well as ensuring that proper distribution to target groups is achieved. Nebraska has enlisted the assistance of ethnic community centers and support groups to outreach to and guide families through the application process. Another barrier may be the lack of understanding of the application process and how to complete the application. Nebraska

has addressed this barrier through a network of community groups and public health nurses trained and available to assist families to complete the application and guide them through the process. The availability of the statewide toll-free telephone hotline also assists families with questions about the application and/or the process.

Enrollment

Monthly enrollment of children under age 19 years has increased by 9,467 children from October 1, 1999 to September 30, 2000. Enrollment has been successful due to changes made with the implementation of CHIP including: Shortened 1-page (2-sided) application form; Elimination of the face-to-face interview in the HHS local office; Reduction in documentation required for verification of information; Implementation of Presumptive Eligibility for Children; Increase in the income eligibility standard for pregnant women.

3. Retention/disenrollment

   Monthly enrollment of children under age 19 years continues to increase reflecting retention of children in the program. Retention success can, in part, be attributed to 12-month continuous enrollment for all children.

4. Benefit structure

   The benefit package offered by Kids Connection is generous when compared to private health insurance. Because the CHIP program is a Medicaid-expansion, all Medicaid covered services are part of the CHIP benefit package. Coverage for services delivered via telehealth communication began July 1, 2000. Coverage of Pneumoccal Vaccine for children began August 1, 2000.

5. Cost-sharing

   NA

6. Delivery systems

   NA

7. Coordination with other programs

   Nebraska has been very aggressive in pursuing coordination of outreach and referrals with other programs. Referrals have been coordinated with many programs including Medically Handicapped Children's Program, Maternal and Child Health grantees, WIC clinics, Immunization clinics and community action agencies. As we look toward finding the hard-to-reach children, we acknowledge that it will be even more important to coordinate outreach and referrals with other programs especially community based program services. State legislation authorized the agency to establish a plan for reimbursement for Medicaid administrative activities in schools beginning January 1, 2000. This plan will increase coordination of outreach activities in Nebraska's schools. Nebraska is awaiting federal approval of our plan.

8. Other

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs			
Insurance payments			
Managed care	1,927360	2,300,000	2,830,000
per member/per month rate X # of eligibles			
Fee for Service	6,390,398	8,600,000	11,810,000
Total Benefit Costs	8,317,758	10,900,000	14,640,000
(Offsetting beneficiary cost sharing payments)	0	0	0
Net Benefit Costs	8,317,758	10,900,000	11,640,000
Administration Costs			
Personnel	610,335	628,000	647,000
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing	361,717	372,000	383,000
Outreach/marketing costs			
Other	33,216	34,000	35,000
Total Administration Costs	1,005,268	1,034,000	1,065,000
10% Administrative Cost Ceiling			
Federal Share (multiplied by enhanced FMAP rate)	6,770,381	8,624,702	9,108,215
State Share	2,552,645	3,309,298	3,596,785
TOTAL PROGRAM COSTS	**9,323,026**	**11,934,000**	**12,705,000**

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.
NA

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

XX State appropriations
XX County/local funds
____ Employer contributions
____ Foundation grants
____ Private donations (such as United Way, sponsorship)
____ Other (specify) _____

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

No

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name	**Kids Connection**	
Provides presumptive eligibility for children	_____No __**XX**__ Yes, for whom and how long? **Children age 18 yr. and younger. Until eligibility for Title XIX or Title XXI determined**	_____No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No **younger** __**XX**__ Yes, for whom and how long? **Children age 18 yr. For 3 months prior to the month of request/application**	_____No _____Yes, for whom and how long?
Makes eligibility determination	__**XX**__ State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)* _____	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)* _____
Average length of stay on program	Specify months __**12**__	Specify months _____
Has joint application for Medicaid and SCHIP	_____No __**XX**__ Yes	_____No _____Yes
Has a mail-in application	_____No __**XX**__ Yes	_____No _____Yes
Can apply for program over phone	__**XX**__ No _____Yes	_____No _____Yes

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Can apply for program over internet	**XX** No **Application can be printed from internet,** _____Yes **completed and mailed to HHSS.**	_____No _____Yes
Requires face-to-face interview during initial application	**XX** No _____Yes	_____No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	**XX** No _____Yes, specify number of months _____ What exemptions do you provide?	_____No _____Yes, specify number of months _____ What exemptions do you provide?
Provides period of continuous coverage <u>regardless of income changes</u>	_____No **XX** Yes, specify number of months **12** Explain circumstances when a child would lose eligibility during the time period **Turns 19 yr. old; Enters an ineligible living arrangement; Leaves the state; Dies; Client requests that case be closed.**	_____No _____Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	**XX** No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____	_____No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____
Imposes copayments or coinsurance	**XX** No _____Yes	_____No _____Yes
Provides preprinted redetermination process	**XX** No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	_____ No _____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program

5.2 Please explain how the redetermination process differs from the initial application process.

The redetermination form consists of six questions asking only if circumstances have changed since the original application or last redetermination. Redetermination is handled by mail. If no changes are reported, verifications are not required and income used in the current budget is considered unchanged for redetermination.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher	_**150**% of FPL for children under age _**1 year** _**133**% of FPL for children aged _**1 through 5 years** _**100**% of FPL for children aged _**6 through 18 years**
Medicaid SCHIP Expansion	_**185**% of FPL for children aged _**Birth through 18 years** ____% of FPL for children aged _____ ____% of FPL for children aged _____
State-Designed SCHIP Program	____% of FPL for children aged _____ ____% of FPL for children aged _____ ____% of FPL for children aged _____

6.2 As of September 30, 2000, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter ANA.@*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes _**XX**_ No
If yes, please report rules for applicants (initial enrollment).

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	$ **20% of gross earnings**	$ **20% of gross earnings**	$
Self-employment expenses	$ **20% of gross earnings**	$ **20% of gross earnings**	$
Alimony payments Received	$	$	$
Paid	$	$	$
Child support payments Received	$	$	$
Paid	$	$	$
Child care expenses	$ **100% of actual costs**	$ **100% of actual costs**	$
Medical care expenses	$	$	$
Gifts	$	$	$
Other types of disregards/deductions (specify) **Health Insurance Premiums**	$ **100%**	$	$

6.3 For each program, do you use an asset test?
Title XIX Poverty-related Groups _**XX**No ____Yes, specify countable or allowable level of asset test_____

Medicaid SCHIP Expansion program	_**XX**No	____Yes, specify countable or allowable level of asset test_____
State-Designed SCHIP program	____No	____Yes, specify countable or allowable level of asset test_____
Other SCHIP program_____	____No	____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2000? ___ Yes _**XX** No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

A. Family coverage
No changes planned

B. Employer sponsored insurance buy-in
No changes planned

C. 1115 waiver
No changes planned

D. Eligibility including presumptive and continuous eligibility
No changes planned

E. Outreach
Implement administrative activities with schools to include outreach for children as required by state legislation.

F. Enrollment/redetermination process
No changes planned

G. Contracting
No changes planned

H. Other
No changes planned